National Consensus Standards for Health and Well Being

Standing Committee Orientation

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NATIONAL QUALITY FORUM

Welcome & Introductions

NQF Project Staff

- Adeela Khan, MPH
  - Project Manager, Performance Measurement
- Kaitlynn Robinson-Ector, MPH
  - Project Analyst, Performance Measurement
- Elisa Munthali, MPH
  - Managing Director, Performance Measurement
- Ashley Morsell, MPH
  - Project Manager, Performance Measurement
- Robyn Nishimi, PhD
  - Project Consultant

Standing Committee

- Sarah Sampsel, MPH (Co-Chair)
- Amir Qaseem, MD, PhD, MHA (Co-Chair)
- Chisara N. Asomugha, MD, MSPH
- John Auerbach, MBA
- Michael Baer, MD
- Ron Bialek, MPP, CQIA
- Juan Emilio Carrillo, MD, MPH
- Jane Chiang, MD
- Eric K. France, MD, MSPH
- Caroline Rosenthal Gelman, PhD, MSW
- Catherine Hill, DNP, APRN
- David Krol, MD, MPH
- Margaret Luck, SD
- Thomas McInerny, MD
- Patricia McKane, DVM MPH
- Amy Minnich, RN, MHSA
- Jacqueline Moline, MD, MSc
- Marcel Salive, MD, MPH
- Sarah Sampsel, MPH
- Katie Sellers, DrPH
- Jason Spangler, MD, MPH
- Michael Stoto, PhD
- Robert Otto Valdez, PhD
- Arjun Venkatesh, MD, MBA

Agenda for the Call

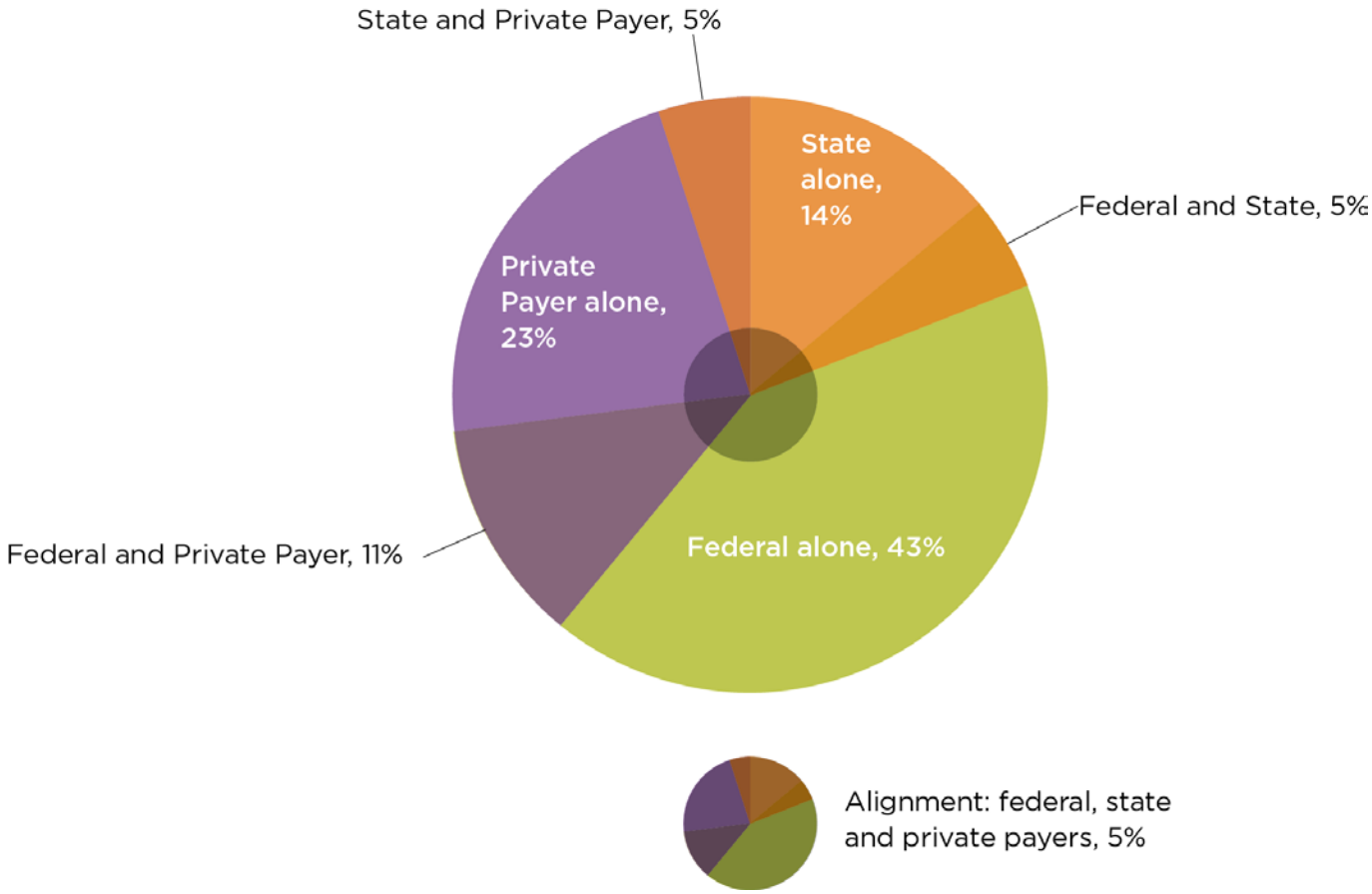
- Background on NQF and project
- Current project focus
- Overview of NQF criteria
- Role of the Committee
- SharePoint Tutorial
- Measure Evaluation Process

NQF Mission


Board of Directors
Standing Committees
8 Membership Councils
Measure Applications Partnership (MAP)
National Priorities Partnership (NPP)
Standing committees for clinical measures and information technology
Neutral Convener
Standard Setting Organization
1 Build Consensus
2 Endorse National Consensus Standards
3 Education and Outreach

Who Uses NQF-endorsed Measures?

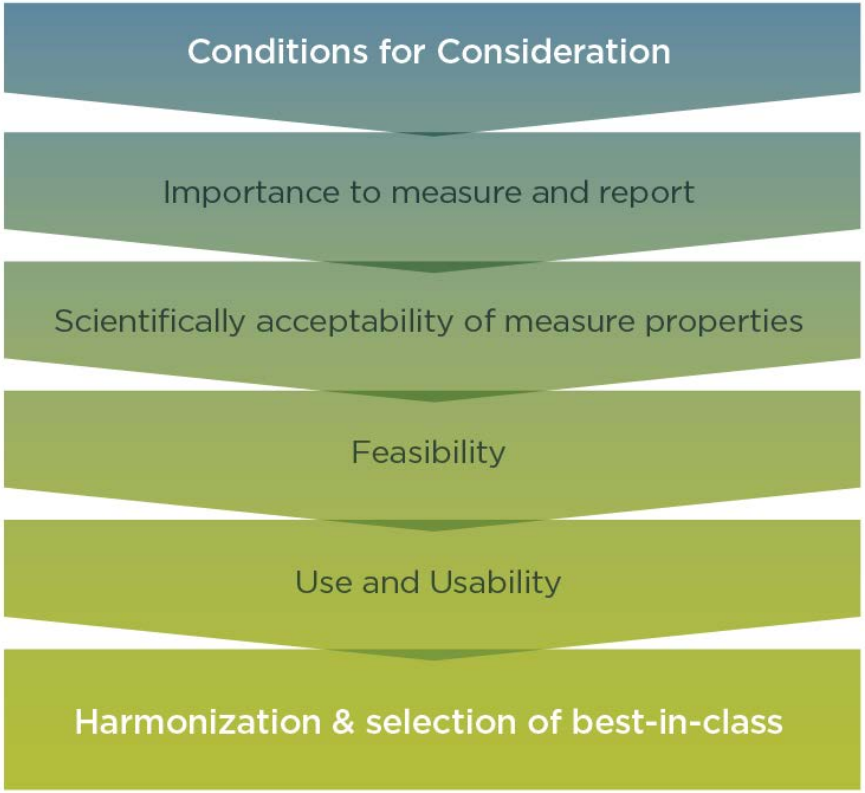
- Approximately 700 endorsed measures
- Various users
  - Federal
  - State
  - Community
  - Facility



NQF Consensus Development Process (CDP)

8 Steps for Measure Endorsement

NQF Measure Evaluation Criteria



Health and Well Being Portfolio of Measures

- NQF **currently has 64 endorsed measures** in the area of Health and Well Being
- This project will evaluate measures and seek to identify and endorse new measures that can be used to assess populations health and health and well being across all levels of analysis, including healthcare providers and communities.
- This project will address a sub- set of health and well being measures covering the following topic areas:
    - *measures that assess health-related behaviors (e.g. smoking, diet) and practices to promote healthy living;* **(6)**
    - *community-level indicators of health and disease (e.g. disease incidence and prevalence) and community interventions (e.g. mass screening);* **(3)**
    - *primary prevention and screening (e.g. influenza immunization);*
    - *modifiable social, economic, environmental determinants of health with demonstrable relationship to population health outcomes;* **(9)**

Measures Under Review

- **Health-Related Behaviors and Practices to Promote Healthy Living**
  - 0272: Diabetes, short-term complications (PQI 1)
  - 0274: Diabetes, long-term complications (PQI 3)
  - 0284: Dehydration (PQI 10)
  - 0281: Urinary infections (PQI 12)
  - 0285: Lower extremity amputations among patients with diabetes (PQI 16)
  - 0638: Uncontrolled Diabetes Admission Rate (PQI 14)
- **Community-Level Indicators of Health and Disease**
  - 0724: Measure of Medical Home for Children and Adolescents
  - 0727: Gastroenteritis Admission Rate (pediatric)
  - 0728: Asthma Admission Rate (pediatric)

Measures Under Review (cont.)

- **Modifiable Social, Economic, & Environmental Determinants of Health**
  - 0717: Number of School Days Children Miss Due to Illness
  - 0719: Children Who Receive Effective Care Coordination of Healthcare Services When Needed
  - 0720: Children Who Live in Communities Perceived as Safe
  - 0721: Children Who Attend Schools Perceived as Safe
  - 1333: Children Who Receive Family-Centered Care
  - 1340: Children with Special Health Care Needs (CSHCN) who Receive Services Needed for Transition to Adult Health Care
  - 1346: Children Who Are Exposed To Secondhand Smoke Inside Home
  - 1348: Children Age 6-17 Years who Engage in Weekly Physical Activity
  - 1349: Children Age 6-17 Years who Engage in Weekly Physical Activity

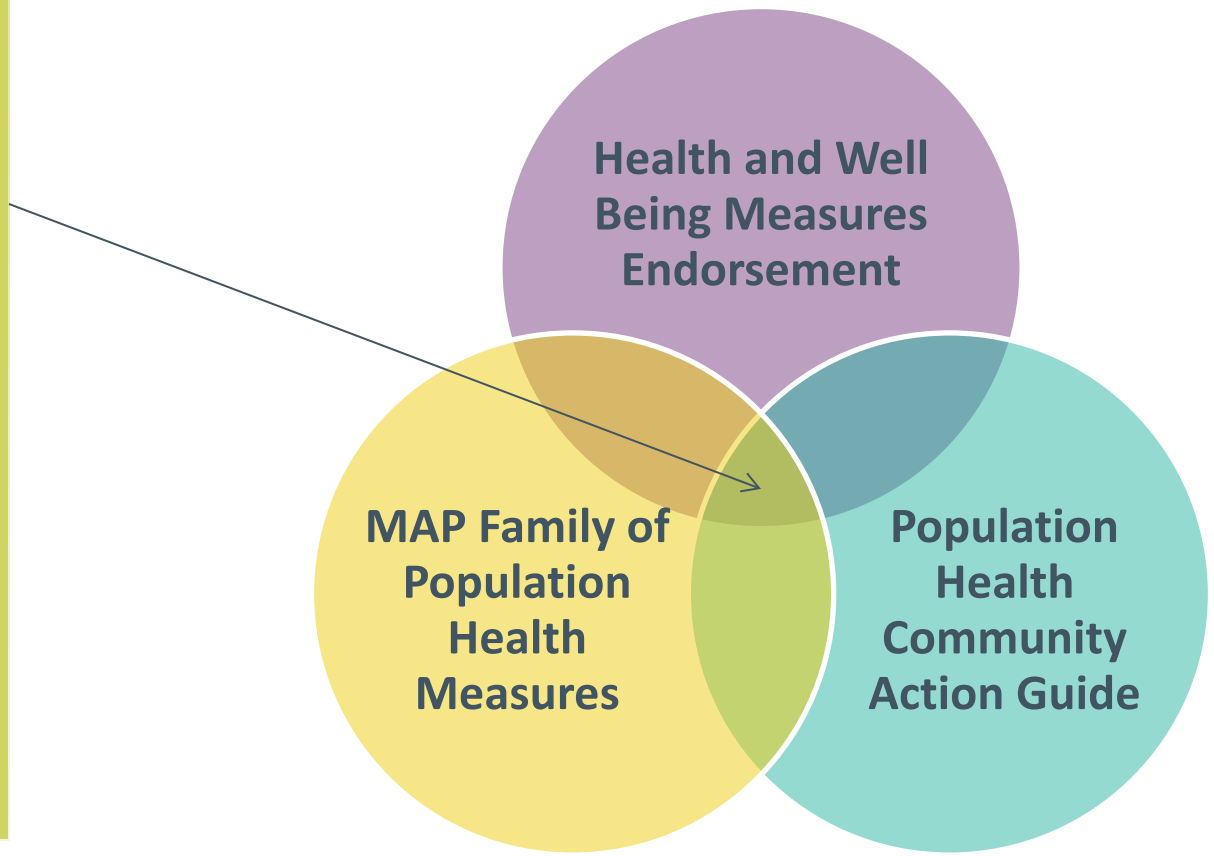
Measures Under Review (cont.)

- **Oral Health**
  - 2508 : Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk
  - 2509 : Prevention: Dental Sealants for 10-14 Year-Old Children at Elevated Caries Risk
  - 2511 : Utilization of Services, Dental Services
  - 2517 : Oral Evaluation, Dental Services
  - 2518 : Care Continuity, Dental Services
  - 2528 : Prevention: Topical Fluoride for Children at Elevated Caries Risk, Dental Services
- **Screenings**
  - 2372 : Breast Cancer Screening

Population Health across NQF Programmatic Areas

NQF's Current Work on Population Health

- Aligned with NQS' Three-Part Aim
- Focus beyond medical model – increased emphasis on determinants of health and improvement activities
- Address measurement, measure gaps, methodological and other challenges of population health measure development
- Opportunity to leverage population health activities and to exchange ideas between committees



Prior Consensus Development Project: Population Health Phase I and II 2012

Project Summary

- NQF commissioned a white paper that included an environmental scan of existing measures and guidance for assessing and measuring population health, determinants of health and improvement activities.
- The Steering Committee developed additional guidance and context for measures addressing population health issues.
- Phase I endorsed 19 influenza and pneumococcal immunizations measures across many healthcare settings, as well as specific cancer, sexually transmitted infections, and osteoporosis measures.
- Phase II endorsed 5 healthy lifestyle behavior and broader population-level measures, including those that assess social, economic, and environmental determinants of health and outcomes.

MAP: Measure Applications Partnership

Population Health Task Force

- The Population Health Task Force will convene to identify a "family" of aligned measures that includes available measures and measure gaps that span programs, care settings, and levels of analysis related to the National Quality Strategy (NQS) priority of Healthy People/Healthy Communities. The findings of the MAP Population Health Task Force will be included in the MAP Families of Measures Report delivered to HHS in the summer of 2014.
  - **Families of Measures**
    - Related available measures and measure gaps that span programs, care settings, levels of analysis, and populations for specific topic areas related to the NQS (e.g., care coordination family of measures, diabetes care family of measures)

Multistakeholder Input on a National Priority: Improving Population Health by Working with Communities

- Through a multistakeholder, collaborative process, NQF will develop a Guide for Community Action to Improve Population Health. The Guide will offer communities practical guidance on:
  - How can individuals and multistakeholder groups come together to address community health improvement?
  - Which individuals and organizations should be at the table?
  - What processes and methods should communities use to assess their health?
  - What data are available to assess, analyze, and address community health needs, and measure improvement?
  - What incentives exist that can drive alignment and coordination to improve community health?
  - How can communities advance more affordable care by achieving greater alignment, efficiency, and cost savings?
- Iterative process with input from multiple stakeholders, including communities.
  - First draft of the Guide will be available for a 15-day public comment period in April 2014.

Roles and Responsibilities

Role of the Standing Committee
General Duties

- Act as a proxy for the NQF multi-stakeholder membership
- Serve 2-year or 3-year terms
- Work with NQF staff to achieve the goals of the project
- Evaluate candidate measures against the measure evaluation criteria
- Respond to comments submitted during the review period
- Respond to any directions from the CSAC

Role of the Standing Committee
Measure Evaluation Duties

- All Members review ALL measures
- Evaluate measures against each criterion
  - Indicate the extent to which each criterion is met and rationale for the rating
- Make recommendations to the NQF membership for endorsement
- Oversee Health and Well Being portfolio of measures

Role of the Standing Committee Co-Chairs

- Facilitate Standing Committee (SC) meetings
- Work with NQF staff to achieve the goals of the project
- Assist NQF in anticipating questions and identifying additional information that may be useful to the SC
- Keep SC on track to meet goals of the project without hindering critical discussion/input
- Represent the SC at CSAC meetings
- Participate as a SC member

Role of NQF Staff

- **NQF project staff works with SC to achieve the goals of the project and ensure adherence to the consensus development process:**
  - Organize and staff SC meetings and conference calls
  - Guide the SC through the steps of the CDP and advise on NQF policy and procedures
  - Review measure submissions and prepare materials for Committee review
  - Draft and edit reports for SC review
  - Ensure communication among all project participants (including SC and measure developers)
  - Facilitate necessary communication and collaboration between different NQF projects

Role of NQF Staff
Communication

- Respond to NQF member or public queries about the project
- Maintain documentation of project activities
- Post project information to NQF website
- Work with measure developers to provide necessary information and communication for the SC to fairly and adequately evaluate measures for endorsement
- NQF project staff works with communications department to publish final report

SharePoint Overview

http://share.qualityforum.org/Projects/health_well_being/SitePages/Home.aspx
[link to Project SharePoint Site]

- Accessing SharePoint
- Standing Committee Guidebook
- Measure Document Sets
- Meeting and Call Documents
- References
- Survey Tool

Activities and Timeline

Process Step	Timeline
Measure submission deadline	February 18, 2014 6:00pm EST
SC member orientation	February 19, 2014 1:00-3:00pm EST
SC member preliminary review and evaluation	March 11-31, 2014
SC Work group calls	March 12, 2014 1:00-3:00pm EDT March 13, 2014 12:00-2:00pm EDT March 25, 2014 1:00-3:00pm EDT March 31, 2014 2:00-4:00pm EDT
SC in-person meeting	April 29-30, 2014
Draft report posted for NQF Member and Public Review and Comment	June 4-July 3, 2014
SC call to review and respond to comments	August 6, 2014 1:00-3:00pm EDT
Draft report posted for NQF Member vote	August 2014
CSAC review and approval	September 2014
Endorsement by the Board	September 2014
Appeals	October 2014

Measure Evaluation Overview

*Please note page numbers denoted correspond to the Standing Committee Guidebook.

**Text in red font denotes additional guidance and context for population health measure evaluation.

Major Endorsement Criteria Hierarchy and Rationale (page 32)

- **Importance to measure and report**: Goal is to measure those aspects with greatest potential of driving improvements; if not important, the other criteria are less meaningful (***must-pass***)
- **Reliability and Validity-scientific acceptability of measure properties** : Goal is to make valid conclusions about resource use; if not reliable and valid, there is risk of improper interpretation (***must-pass***)
- **Feasibility**: Goal is to, ideally, cause as little burden as possible; if not feasible, consider alternative approaches
- **Usability and Use**: Goal is to use for decisions related to accountability and improvement; if not useful, probably do not care if feasible
- Comparison to related or competing measures

Criterion #1: Importance to Measure & Report (page 36-38)

1. **Importance to measure and report -** Extent to which the specific measure focus is evidence-based, important to making significant gains in **population health, improving determinants of health and health outcomes of a population** for a high-impact aspect of **health** where there is variation in **(including geographic variation)** or overall less-than-optimal performance. *Measures must be judged to meet all three subcriteria to pass this criterion and be evaluated against the remaining criteria.*

   1a. Evidence – the measure focus is evidence-based.

   1b. Opportunity for Improvement - Demonstration of opportunity for improvement in **health**, i.e., data demonstrating considerable variation, or overall less-than-optimal performance, in **health across providers (healthcare, public health, and other partners) and/or population groups, (including but not limited to disparities in care.** (pages 41-42)

Criterion #1: Importance to Measure & Report (cont.) (page 36-38)

- **1c. High Priority** –a demonstrated high-impact aspect of **health** (e.g., affects **large population** and/or has a substantial impact for a smaller population; **source of significant health disparities**; leading cause of morbidity/mortality; functional health; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).
  (page 42)

*__Note:__ For population health measures, high impact would also be identified by the National Prevention Strategy and the DHHS Consensus Statement on Quality in Public Health.

1d. Quality construct and rationale (composite measures)

1a Evidence **(page 36-37)**

Requirements for 1a.

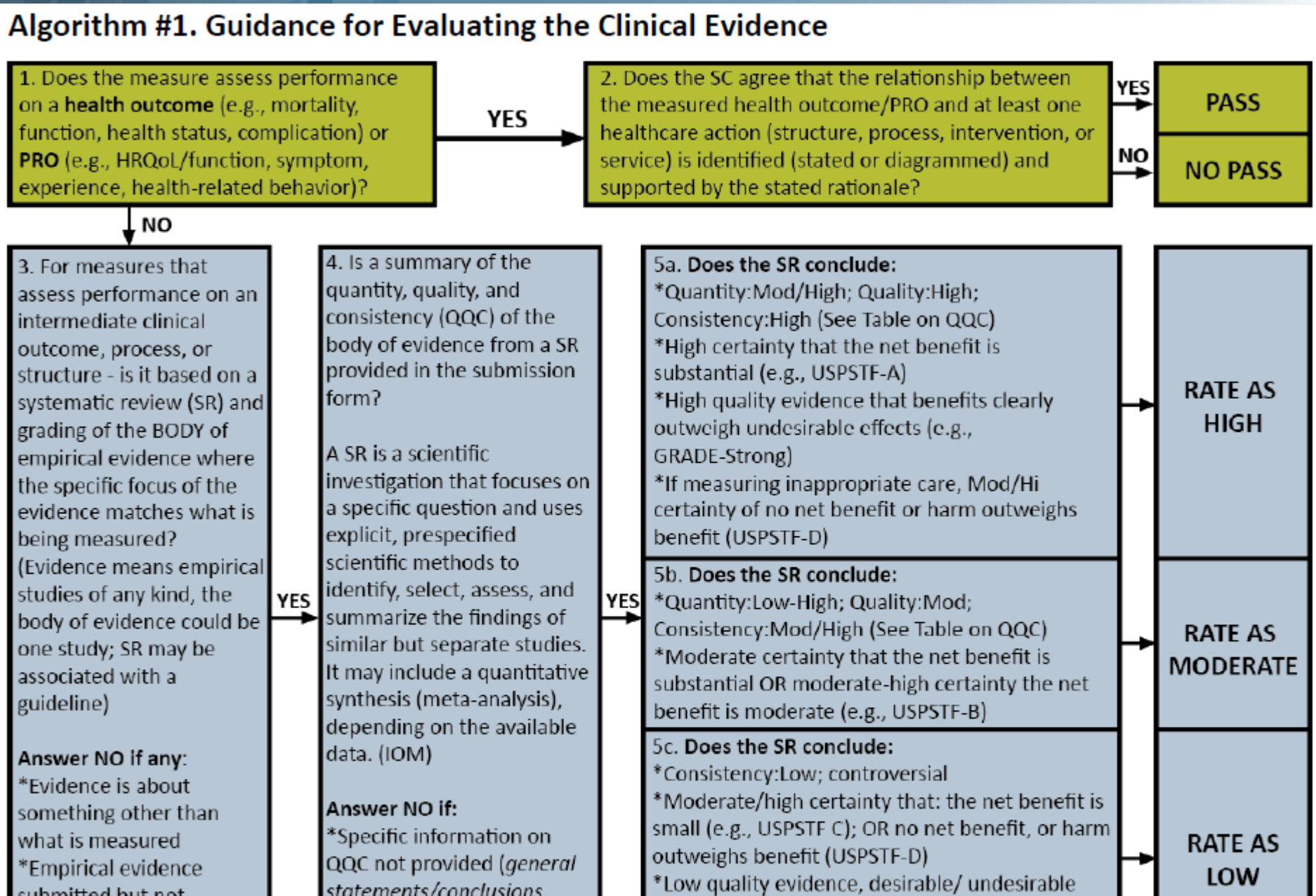
- Health Outcome - a rationale supports the relationship of **the health outcomes in the population to strategies to improve health.**
- Health determinant, Intermediate outcome, Process, or Structure - a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence that the measure focus leads to a desired health outcome.
  - Empiric studies (expert opinion is not evidence)
  - Systematic review and grading of evidence
    - Clinical Practice Guidelines – variable in approach to evidence review

1a Evidence (cont.) **(page 36-37)**

Requirements for 1a.

- **Experience with care, services or other health determinants**: evidence that the measured aspects of care are those valued by **people and populations** and for which the **respondent** is the best and/or only source of information OR that experience is correlated with desired outcomes.

Algorithm #1 – page 37



Criterion # 2: Reliability and Validity – Scientific Acceptability of Measure Properties (page 43 -46)

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of health care delivery

2a. **Reliability (must-pass)**

2a1. The measure is well defined and precisely specified so it can be implemented consistently within and across organizations, **multi-stakeholder groups, populations or entities with shared accountability for health** and allow for comparability.

2a2. Reliability testing—data elements or measure score

Criterion # 2: Reliability and Validity – Scientific Acceptability of Measure Properties (page 43 -46)

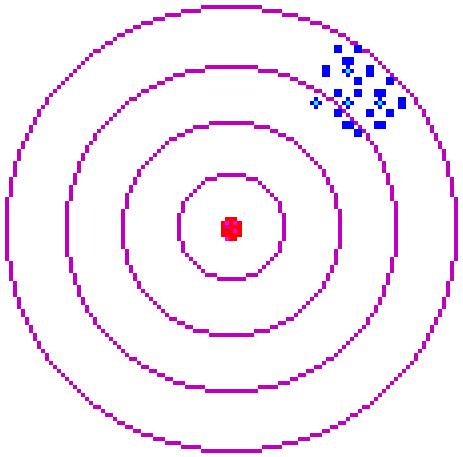
Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of health care delivery

2b. **Validity (must-pass)**

- 2b1. Specifications consistent with evidence
- 2b2. Validity testing—data elements or measure score
- 2b3. Justification of exclusions—relates to evidence
- 2b4. Risk adjustment
- 2b5. Identification of differences in performance
- 2b6. Comparability of data sources/methods

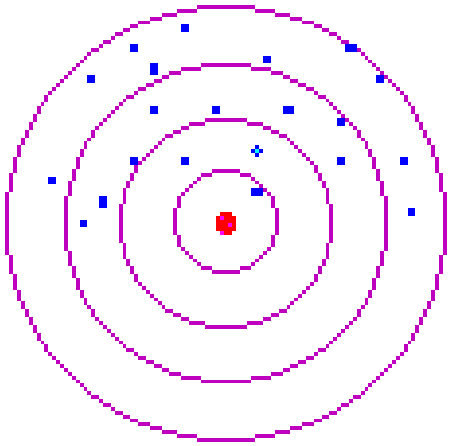
Reliability and Validity

Assume the center of the target is the true score…



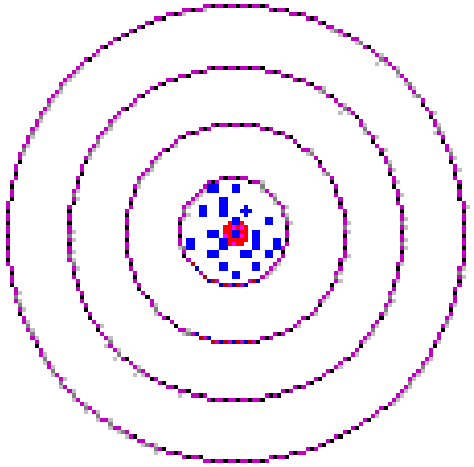
Reliable Not Valid

Consistent, but wrong



Neither Reliable Nor Valid

Inconsistent & wrong



Both Reliable And Valid

Consistent & correct

Measure Testing – (Key Points page 46)

Empirical analysis to demonstrate the reliability and validity of the *measure as specified,* including analysis of issues that pose threats to the validity of conclusions about quality of care such as exclusions, risk adjustment/stratification for outcome and resource use measures, methods to identify differences in performance, and comparability of data sources/methods.

Reliability Testing (page 46)
Key points - page 47

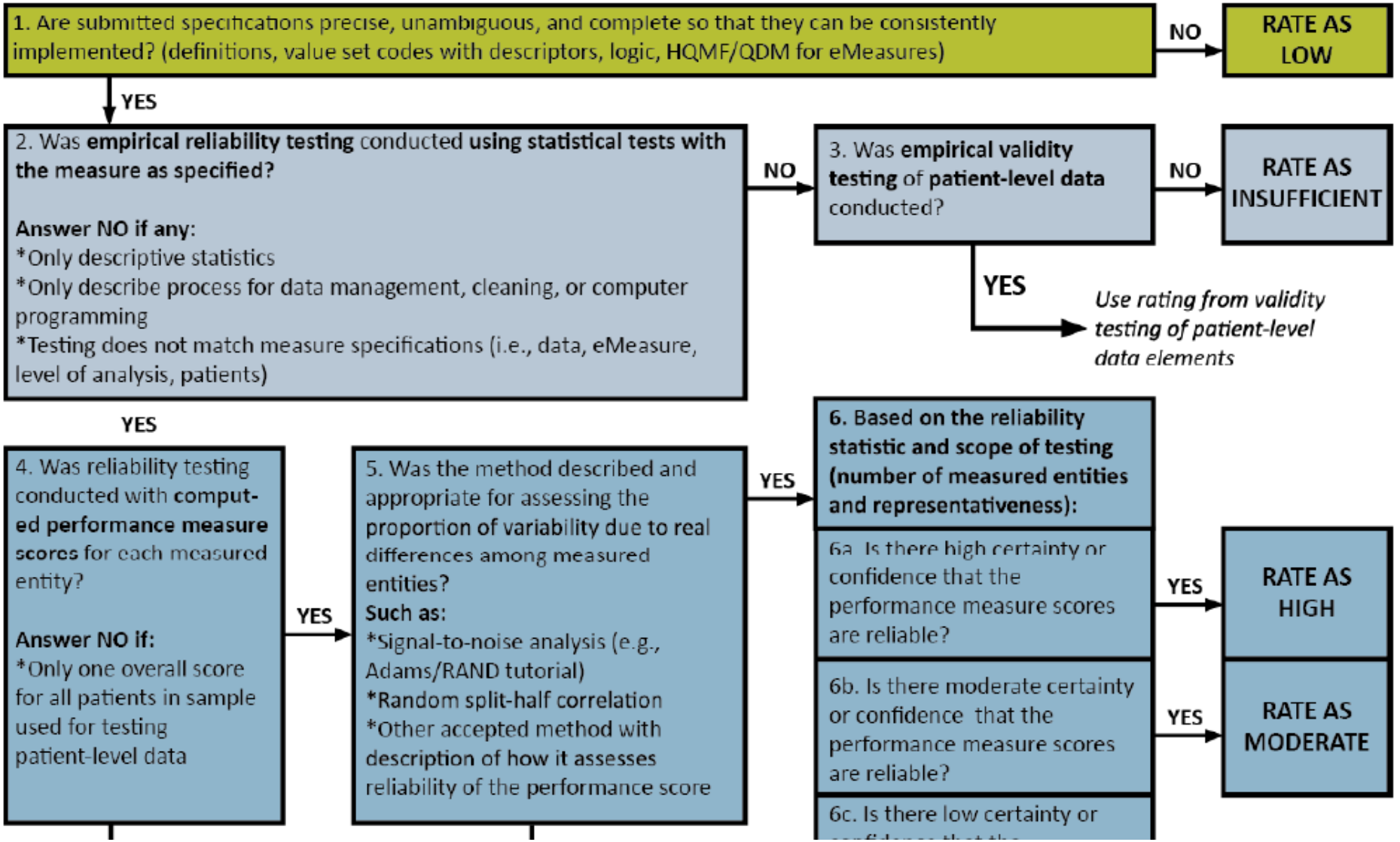
- Reliability of the ***measure score*** refers to the proportion of variation in the performance scores due to systematic differences across the measured entities in relation to random variation or noise (i.e., the precision of the measure).
  - Example - Statistical analysis of sources of variation in performance measure scores (signal-to-noise analysis)

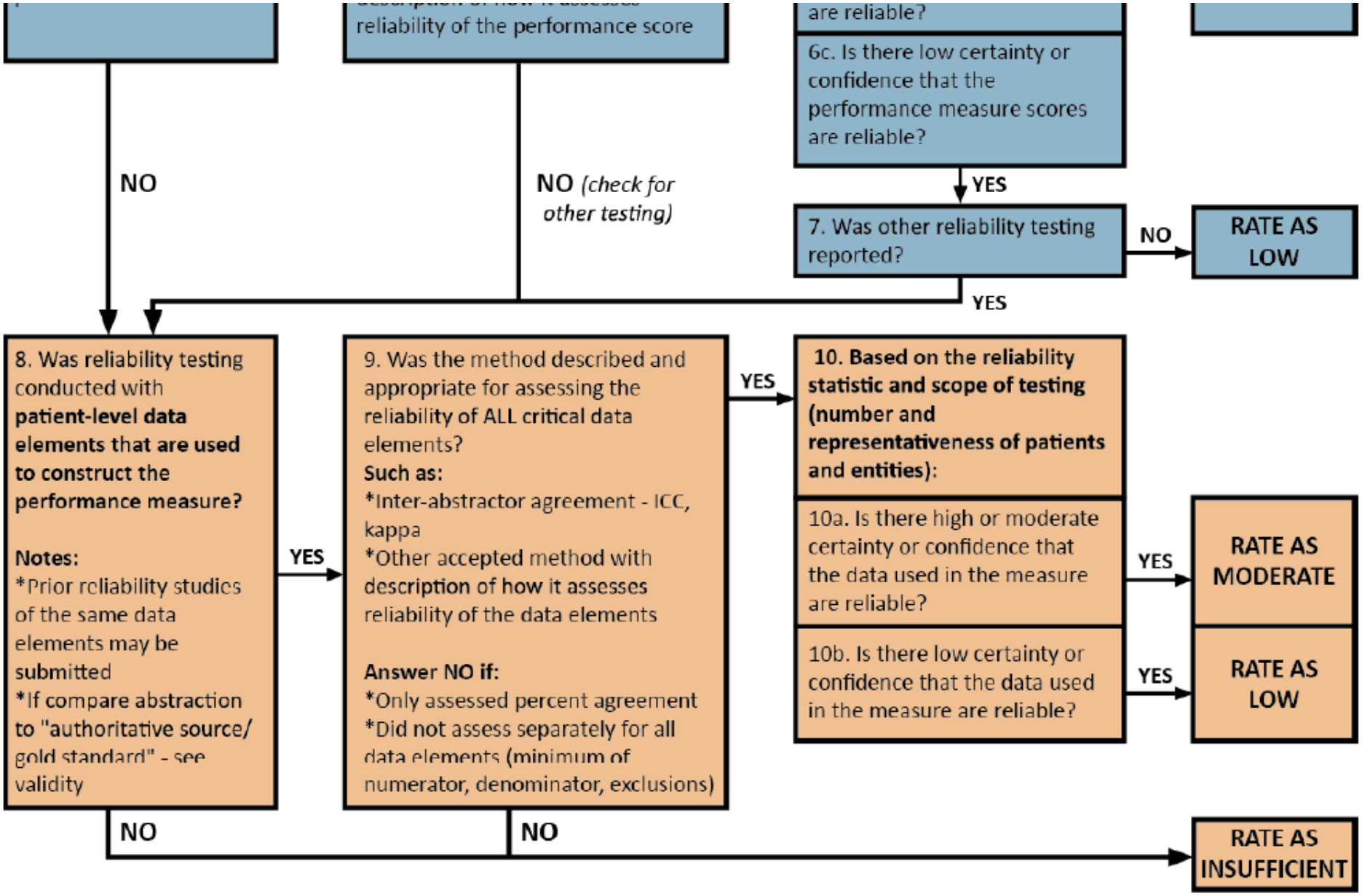
- Reliability of the ***data elements*** refers to the repeatability/reproducibility of the data and uses patient-level data
  - Example –inter-rater reliability

- Consider whether testing used an appropriate method and included adequate representation of providers and patients and results are within acceptable norms

- Algorithm #2 – page 48

Algorithm #2 – page 48

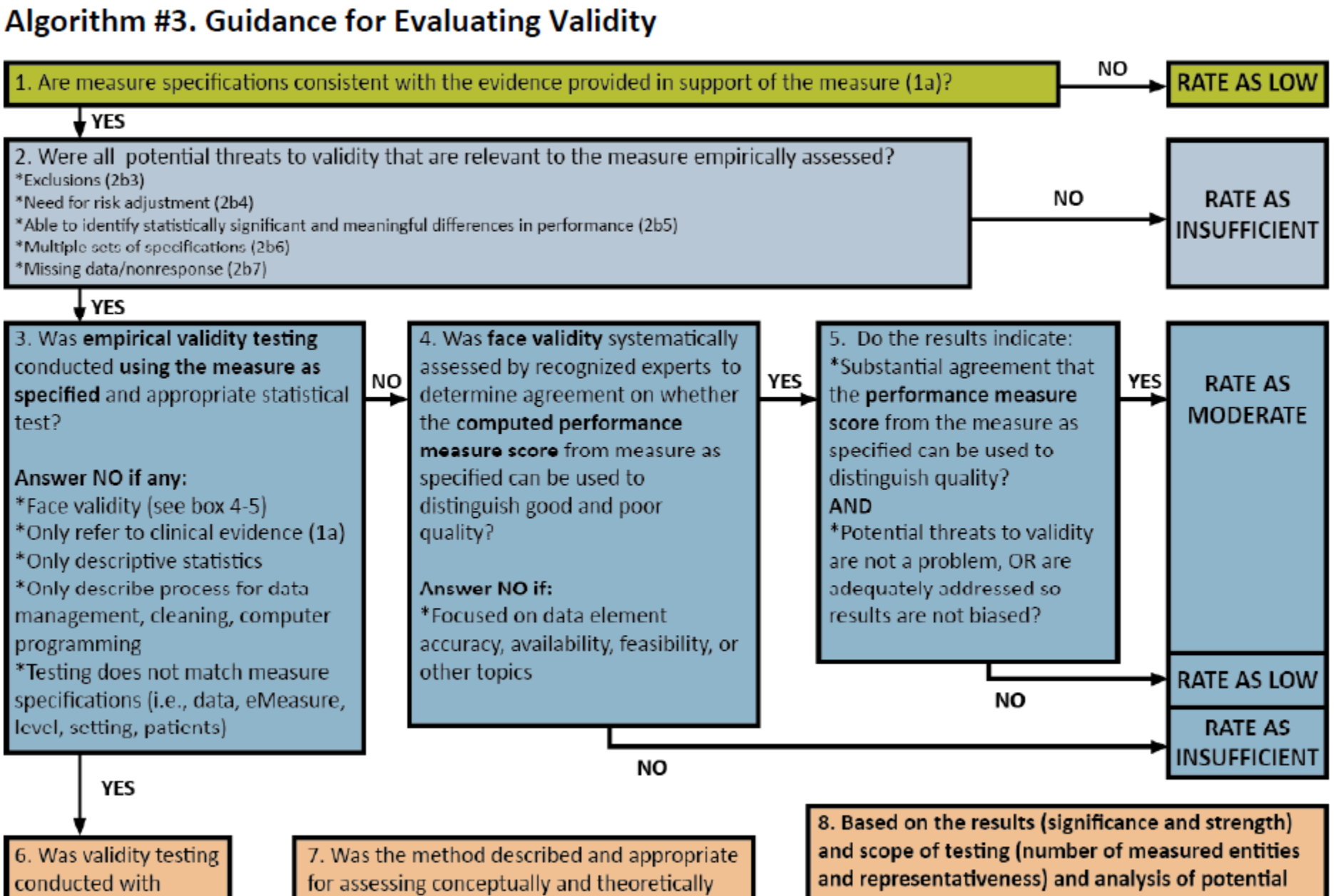


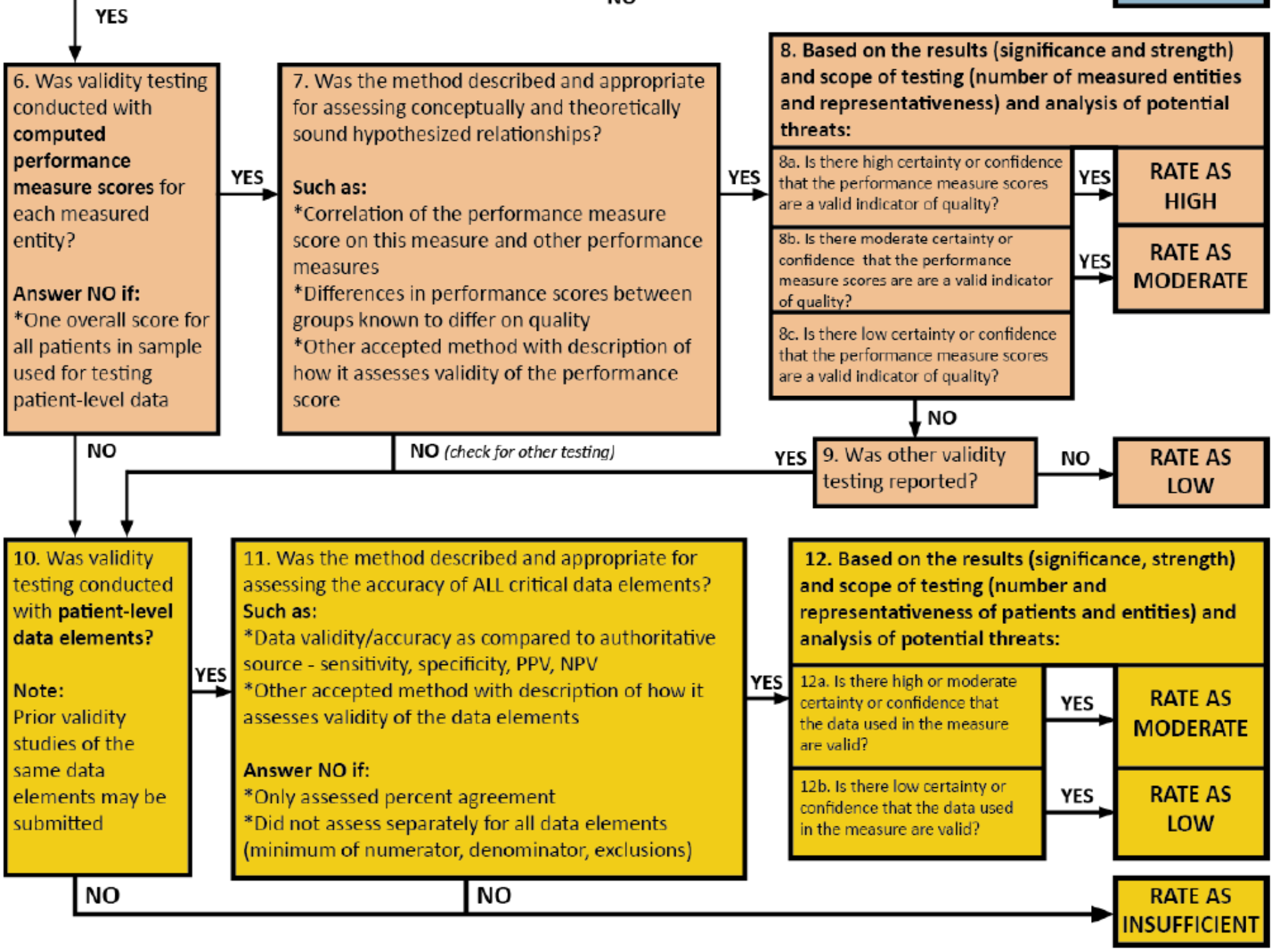

reliability of the performance score
are reliable?
6c. Is there low certainty or confidence that the performance measure scores are reliable?
NO
NO (check for other testing)
YES
7. Was other reliability testing reported?
NO
RATE AS LOW
YES
8. Was reliability testing conducted with patient-level data elements that are used to construct the performance measure?
Notes:
*Prior reliability studies of the same data elements may be submitted
*If compare abstraction to "authoritative source/ gold standard" - see validity
YES
9. Was the method described and appropriate for assessing the reliability of ALL critical data elements?
Such as:
*Inter-abstractor agreement - ICC, kappa
*Other accepted method with description of how it assesses reliability of the data elements
Answer NO if:
*Only assessed percent agreement
*Did not assess separately for all data elements (minimum of numerator, denominator, exclusions)
YES
10. Based on the reliability statistic and scope of testing (number and representativeness of patients and entities):
10a. Is there high or moderate certainty or confidence that the data used in the measure are reliable?
YES
RATE AS MODERATE
10b. Is there low certainty or confidence that the data used in the measure are reliable?
YES
RATE AS LOW
NO
NO
RATE AS INSUFFICIENT

Validity testing (pages 49- 51)
Key points – page 51

- **Empiric testing**
  - *Measure score* – assesses a hypothesized relationship of the measure results to some other concept; assesses the correctness of conclusions about quality
  - *Data element* – assesses the correctness of the data elements compared to a "gold standard"
- **Face validity**
  - Subjective determination by experts that the measure appears to reflect quality of care

Algorithm #3 – page 52




YES
6. Was validity testing conducted with **computed performance measure scores** for each measured entity?
Answer NO if:
*One overall score for all patients in sample used for testing patient-level data
YES
7. Was the method described and appropriate for assessing conceptually and theoretically sound hypothesized relationships?
Such as:
*Correlation of the performance measure score on this measure and other performance measures
*Differences in performance scores between groups known to differ on quality
*Other accepted method with description of how it assesses validity of the performance score
YES
8. Based on the results (significance and strength) and scope of testing (number of measured entities and representativeness) and analysis of potential threats:
8a. Is there high certainty or confidence that the performance measure scores are a valid indicator of quality?
YES
RATE AS HIGH
8b. Is there moderate certainty or confidence that the performance measure scores are are a valid indicator of quality?
YES
RATE AS MODERATE
8c. Is there low certainty or confidence that the performance measure scores are a valid indicator of quality?
NO
NO
NO (check for other testing)
YES
9. Was other validity testing reported?
NO
RATE AS LOW
10. Was validity testing conducted with **patient-level data elements?**
Note:
Prior validity studies of the same data elements may be submitted
YES
11. Was the method described and appropriate for assessing the accuracy of ALL critical data elements?
Such as:
*Data validity/accuracy as compared to authoritative source - sensitivity, specificity, PPV, NPV
*Other accepted method with description of how it assesses validity of the data elements
Answer NO if:
*Only assessed percent agreement
*Did not assess separately for all data elements (minimum of numerator, denominator, exclusions)
YES
12. Based on the results (significance, strength) and scope of testing (number and representativeness of patients and entities) and analysis of potential threats:
12a. Is there high or moderate certainty or confidence that the data used in the measure are valid?
YES
RATE AS MODERATE
12b. Is there low certainty or confidence that the data used in the measure are valid?
YES
RATE AS LOW
NO
NO
RATE AS INSUFFICIENT

Threats to Validity

- Conceptual
  - Measure focus is not a relevant outcome of healthcare or not strongly linked to a relevant outcome
- Unreliability
  - Generally, an unreliable measure cannot be valid
- Patients inappropriately excluded from measurement
- Differences in patient mix for outcome and resource use measures
- Measure scores that are generated with multiple data sources/methods
- Systematic missing or “incorrect” data (unintentional or intentional)

Criterion #3: Feasibility (page 53-54)
Key Points – page 55

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.

3a: Clinical data generated during care process

3b: The required data elements are available in electronic health records, **personal health records, health information exchanges, population data bases**, or other electronic sources. If the required data are not available **in existing electronic sources**, a credible, near-term path to electronic collection is specified.

3c: Susceptibility to inaccuracies, errors, **inappropriate comparison across populations,** or unintended consequences and the ability to audit the data items to detect such problems are identified.

Criterion #4: Usability and Use (page 54)

Extent to which potential audiences (e.g., consumers, purchasers, providers, policymakers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

***Note: Intended audiences can include community members and coalitions.**

4a: Accountability: Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement

4b: Improvement: Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated

4c: Benefits outweigh the harms: The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4d. Transparency: Data and result detail are maintained such that the resource use measure, including the clinical and construction logic for a defined unit of measurement can be deconstructed to facilitate transparency and understanding.

5. Related or Competing Measures (page 55-56)

If a measure meets the four criteria and there are endorsed/new related measures (same measure focus or same target population) or competing measures (both the same measure focus and same target population), the measures are compared to address harmonization and/or selection of the best measure.

- 5a. The measure specifications are harmonized with related measures **OR** the differences in specifications are justified.
- 5b. The measure is superior to competing measures (e.g., is a more valid or efficient way to measure) **OR** multiple measures are justified.

Questions?

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Next Steps

- Measure Evaluation Q&A Calls: March 4, 2014 10-11am EST ***OR*** March 17, 2014 12-1pm EST.
- Work Group calls will be held March 12-31, 2014.
  - Complete your preliminary evaluation surveys: Varies by assigned work group; will be distributed by February 28.
- Full Committee meeting: April 29-30, 2014 in Washington, DC
  - Travel logistics information sent by March 1.

Project Contact Info

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Questions?

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